Leon County Emergency Medical Services

Physicians Certification Statement for Ambulance Transport

This form must be filled out for any transport from any facility, regardless of the patient's Medicare Status.

FAX TO – (850)921-4100

Medicare requires under 42 CFR part 410.40(d) that ambulance transport providers obtain a *Certificate of Medical Necessity* signed by the patient's physician or representatives noted below for the provision of non-emergency transportation. This form has been designated to assist the physician, the facility, the Medicare Beneficiary, and the ambulance provider to determine if Medical Necessity has been met and **MUST BE COMPLETED PRIOR TO ANY NON-EMERGENCY TRANSPORT.** A copy of this form should be **faxed to (850) 921-4100****, in addition to calling to setup the transport. The original form should be given to the transporting crew. To setup a transport call 921-0900.

*The ENTIRE form must be completed properly and legibly PRIOR to transport.

**Non-Emergency transports will not be completed without a completed Physician Certification.

Section 1 – Patient Information

Patients Name _____ Transport Date _____ SSN _____

D.O.B. _____ Transport from _____ Rm____ Destination _____ Rm____

Physician Printed Name _____ Physician Office Fax # _____

Section 2 – Medical Necessity (Check ALL that apply)

The Undersigned does hereby certify that the above named patient:

☐ is unable to get up from bed without assistance,

☐ is unable to ambulate, and

☐ is unable to sit in a chair or wheelchair (for duration of transport).

In addition, the patient's condition is such that any other means of transportation (such as a stretcher service) is contraindicated and this patient:

☐ requires continuous oxygen & monitoring by trained staff

☐ requires airway monitoring & suctioning

☐ is ventilator dependent

☐ requires cardiac monitoring

☐ requires isolation precautions (VRE, MRSA, etc.)

☐ is exhibiting decreased level of consciousness

☐ other (explain) _____

☐ is seizure prone & requires trained monitoring

☐ has decubitus ulcers & requires wound precautions

☐ requires restraints

☐ requires IV maintenance

☐ Weight exceeds wheelchair or stretcher van safety limit. Pt's approximate weight: _____

☐ is comatose & requires trained monitoring

Section 3 – Certification Signature

Printed Name of Certifying Physician _____ Phone# _____

Signature of Physician or Authorized Representative _____ Date _____

NOTE: If the patient does not meet any of the above criteria of medical necessity for ambulance transport then the transferring facility (by signature of the physician/facility representative) is accepting responsibility for all ambulance charges relating to the patients transfer. (Quoted Price of non-medically necessary transfer: $684.00 + $12.82/mile)

EMS USE ONLY: **Medic Unit** _____ **Run#** _____ **Date** _____ Revised October 2006